Palmetto
Bone & Joint, P.A.

DATE: _____

PATIENT INFORMATION

NAME (FIRST, MIDDLE INITIAL, LAST)	DATE OF BIRTH
ADDRESS	SOCIAL SECURITY NUMBER
CITY, STATE, ZIP CODE	GENDER, RACE
HOME PHONE	PRIMARY LANGUAGE
CELL PHONE	MARITAL STATUS (SINGLE, MARRIED, DIVORCED, WIDOW)
EMAIL ADDRESS	PRIMARY DOCTOR
WORK STATUS	EMPLOYER/WORK PHONE (IF APPLICABLE)

RESPONSIBLE PERSON OF MINOR PATIENT

NAME (FIRST, MIDDLE INITIAL, LAST)	RELATIONSHIP TO PATIENT
DATE OF BIRTH	SOCIAL SECURITY NUMBER
ADDRESS (IF DIFFERENT FROM PATIENT)	PHONE NUMBER/S

POLICY HOLDER INFORMATION (IF OTHER THAN THE PATIENT)

PRIMARY INSURED'S NAME /DATE OF BIRTH	SECONDARY INSURED'S NAME/DATE OF BIRTH
INSURED'S ADDRESS	INSURED'S ADDRESS
EMPLOYER NAME AND NUMBER	EMPLOYER NAME AND NUMBER

Height: _____ **Weight:** _____

Which body part are we seeing you for today? _____

Which side is bothering you? LEFT RIGHT BOTH

Is this accident related? YES NO **If yes, what is the date of your injury?** _____

How did your injury occur?

_____

_____

Did you have any X-Rays? YES NO **If yes, where were they done?** _____

Did you bring them with you? YES NO

CONSENT TO TREAT

1. MEDICAL CONSENT: THE UNDERSIGNED CONSENTS FOR TREATMENT BY PALMETTO BONE & JOINT, PA. THIS MAY INCLUDE OFFICE VISITS, TESTING, XRAYS, OR ANY OTHER TREATMENT DIRECTLY RELATED TO THE PATIENTS CARE. THE UNDERSIGNED UNDERSTANDS THAT THE PRACTICE OF MEDICINE IS NOT AN EXACT SCIENCE AND THAT DIAGNOSIS AND TREATMENT MAY INVOLVE RISK. THE UNDERSIGNED ACKNOWLEDGES THAT NO GUARANTEES HAVE BEEN MADE AS TO THE RESULTS OF EXAMINATION AND/OR TREATMENT.

2. PAYMENT OF SERVICE: THE UNDERSIGNED INDERSTAND THAT PAYMENT IS EXCPECTED AT THE TIME OF SERVICE FOR ALL OFFICE VISITS, TESTING, AND INJECTIONS. INSURANCE WILL BE FILED FOR FRACTURES AND SURGERY. PATIENTS WITH MEDICARE, MEDICAID, OR OTHER MANAGED CARE CONTRACTS WITH WHOM WE HAVE AGREEMENTS WILL BE HONERED FOR ALL VISITS. **CO-PAYS ARE EXPECTED AT THE TIME OF SERVICE.**

3. LIABILITY CLAIMS: PALMETTO BONE & JOINT DOES NOT ACCEPT 3RD PARTY LIABILITY. ASSISTANCE WILL BE GIVEN TO PROVIDE THE PATIENT WITH NECESSARY FORMS FOR FILING, BUT PAYMENT IS EXPECTED AT THE TIME OF SERVICE.

4. MEDICAL RECORDS RELEASE: THE PATIENT OR GUARANTOR OF THE ACCOUNT HEREBY AUTHORIZES PALMETTO BONE & JOINT TO RELEASE MEDICAL RECORDS TO ANY REFERRING PHYSICIAN OR FAMILY PHYSICIAN. AUTHORIZATION IS ALSO GIVEN TO RELEASE RECORDS TO INSURANCE CARRIERS FOR THE PURPOSE OF PAYMENT OF CLAIMS INCLUDING WORKERS COMP CALIMS AND EMPLOYER.

5. MEDICARE AND MEDICAID AUTHORIZATION: I CERTIFY THAT THE INFORMATION GIVEN BY ME IN APPLYING FOR PAYMENT UNDER TITLE XVII AND IXIX OF THE SOCIAL SECURITY ACT IS CORRECT AND I REQUEST PAYMENT FOR AUTHORIZED BENEFITS TO BE MADE ON MY BEHALF. I AUTHORIZE PALMETTO BONE & JOINT TO RELEASE MEDICARE BUREAU, HEALTH CARE FINANCING ADMINISTRATION OR ITS INTERMEDIARIES OR CARRIERS, ANY INFORMATION ABOUT ME NEEDED FOR MEDICARE CLAIMS, INCLUDING MEDICAL INFORMATION FOR THE PURPOSE OF PROCESSING A CLAIM AND MEDICARE BENEFITS. I ALSO AUTHORIZE THE RELEASE OF MEDICAL AND RELATED INFORMATION ABOUT MY TREATMENT TO THE UTILIZATION AND QUALITY CONTROL PEER REVIEW ORGANIZATION RESPONSIBLE FOR REVIEWING THE MEDICAL CARE FURNISHED TO ME.

6. FINANCIAL RESPONSIBILITY: I ACKNOWLEDGE FULL RESPONSIBILTY FOR SERVICES RENDERED AND AGREE TO MAKE DEFINITE FINANCIAL ARRANGEMENTS FOR PAYMENT. I UNDERSTAND THAT THE CHARGES MADE FOR PROFESSIONAL SERVICES MAY NOT BE COVERED IN FULL MY HEALTH INSURANCE AND THEREFORE, I AM SOLELY RESPONSIBLE FOR PAYMENT OF ALL UNCOVERED SERVICES. I FURTHER REQUEST THAT PAYMENT BE MADE DIRECTLY TO THE PHYSICIAN ACCORDING TO ASSIGNMENT FOR BENEFITS.

I ACKNOWLEDGE I RECIEVED THE PALMETTO BONE & JOINT NOTICE OF PRIVACY PRACTICES SETTING FORTH THE WAYS TO MY PERSONAL HEALTH INFORMATION MAY BE USED OR DISCLOSED BY PALMETTO BONE & JOINT AND OULINES MY RIGHTS WITH RESPECT TO SUCH INFORMATION.

Patient Signature:_____ **Date:**_____

EMERGENCY CONTACT & PERSON/S WE MAY RELEASE INFORMATION TO

CONTACT NAME/RELATIONSHIP	PHONE NUMBER/S
CONTACT NAME/RELATIONSHIP	PHONE NUMBER/S
CONTACT NAME/RELATIONSHIP	PHONE NUMBER/S

NARCOTIC MEDICATION AGREEMENT

I am aware that the use of such medicine has certain risks associated with it including, but not limited to: sleepiness or drowsiness, constipation, nausea and vomiting, itching, lightheadedness, dizziness, confusion, allergic reaction, slowing of breathing rate, slowing of reflexes or reaction time, kidney or liver disease, sexual dysfunction, physical dependence, tolerance to analgesia, addiction, withdrawal and the possibility that the medicine will not provide complete relief. The overuse of narcotic medication can result in serious health risks including respiratory depression or even death. This medication will be strictly monitored and all of your medications should be filled at the same pharmacy.

- You have the opportunity to ask questions regarding alternatives to the use of narcotic medications.
- You must keep all regular follow up appointments as recommended by our physicians. Failure to comply may cause discontinuation of narcotic prescriptions. You must comply with ALL aspects of the treatment plan including, but not limited to: physical therapy, behavioral management and self-help programs.
- You agree to take narcotic medications ONLY AS PRESCRIBED. Any changes must be discussed and agreed upon with the treating physician.
- If you demonstrate unacceptable behavior patterns, we may discontinue prescribing narcotic medications for you IMMEDIATELY. These behaviors include: hoarding medications, increasing the dosage without the authorization of your treating physician, frequently refilling your prescription, receiving the medication from multiple physicians, altering the prescription, selling medication, taking unapproved use of other drugs (alcohol, sedatives or non-prescription medications inconsistent with drug label). Medications may also be discontinued if there is evidence of rapid tolerance, loss of effectiveness or development of a significant side effect. You must agree that you are not currently abusing illicit or prescription drugs, have never been involved in the sale of or had illegal possession of controlled substances, narcotics, sleeping pills, nerve pills or pain killers.
- SHARING YOUR NARCOTIC MEDICATION IS STRICTLY PROHIBITED! Any sharing will result in immediate cancellation of your prescription refills.
- You agree to have urine tests for medications done at the discretion of the treating physician.
- You must supply documentation of treatment by other physicians for co-existing or related conditions including psychiatric conditions. You agree that Palmetto Bone and Joint physicians will prescribe you narcotic medications. You must also agree to allow our physicians to communicate with the referring physician and pharmacists regarding your use of controlled substances. If it is brought to our attention that other providers are prescribing medications for you, our practice reserves the right to discontinue prescribing medications and/or discharge you from our practice.
- Medications WILL NOT be replaced if they are lost, get wet, destroyed, or left in another location. If medication is stolen, a police report regarding the theft must be produced and an exception MAY be made.
- NARCOTIC MEDICATIONS WILL NOT BE REFILLED EARLY!

**** IF YOU ARE NON-COMPLIANT OR UNCOOPERATIVE WITH THE PHYSICIAN OR OFFICE STAFF, OUR PRACTICE RESERVES THE RIGHT TO DISCHARGE YOU AT ANY TIME. I HAVE READ OR HAD THE AGREEMENT READ TO ME AND I UNDERSTAND IT. I AGREE TO THE TERMS OF THIS CONTRACT.

My pharmacy of choice is: _____ in _____
(location)

If you need to change your pharmacy, our office must be informed so that we have the correct information on file.

Patient signature _____ Date: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

Name : _____ **DOB:** _____

I have received a copy of the Notice of Privacy Practices.

_____ _____

Signature of patient or authorized patient Date

_____

Relationship to individual

Name: _____

What pharmacy and where at:

_____

Are you allergic to any medications? **Yes or No**
If yes, what are you allergic to?

_____

What type of reactions do you experience?

_____

_____

Current Medications

Medications	Dosage

Patient Name: **Date:** **Form:** PHX

Medical disorders: If you have had any of the following, Place Mark inside Circles

- ○ No Medical History
- ○ AIDS/HIV
- ○ **Alcoholism**
- ○ **Alzheimer's**
- ○ **Anemia**
- ○ **Rheumatoid Arthritis**
- ○ **Asthma**
- ○ **Blood Clot Leg**
- ○ **Blood Clot Lung**
- ○ Stroke
- ○ Cancer Breast
- ○ Cancer **Colon**
- ○ Cancer **Lung**
- ○ Cancer **Prostate**
- ○ **COPD**
- ○ **Depression**
- ○ **Diabetes**
- ○ **Drug Abuse**
- ○ Sleep Apnea
- ○ Gout
- ○ Heart Attack
- ○ High Blood Pressure
- ○ Hepatitis
- ○ Kidney Disease
- ○ Osteoarthritis
- ○ Seizures
- ○ Ulcers, Bleeding

○ **Other Disease** (list below) ○ **Blood thinners (Coumadin, Plavix, aspirin, etc)**

Surgical History: If you have had any of the following, Place Mark inside Circles

- ○ No Surgical History Reported
- ○ Carpal Tunnel Left Wrist
- ○ Arthroscopy Left Elbow
- ○ Arthroscopy Left Shoulder
- ○ Arthroscopy Left Ankle
- ○ Arthroscopy Left Knee
- ○ Arthroscopy Left Hip
- ○ Left Hip Replacement
- ○ Left Knee Replacement
- ○ Spinal Fusion
- ○ Other Surgery (list in the box below)
- ○ Cardiac (Heart)
- ○ Carpal Tunnel Right Wrist
- ○ Arthroscopy Right Elbow
- ○ Arthroscopy Right Shoulder
- ○ Arthroscopy Right Ankle
- ○ Arthroscopy Right Knee
- ○ Arthroscopy Right Hip
- ○ Right Hip Replacement
- ○ Right Knee Replacement
- ○ Laminectomy
- ○ Fracture Surgery

Patient Name: **Date:** **Form:** PFHX

Family History:

If any family Member below has any of the following history, Place Mark inside Circles

Father Medical History

- ○ AIDS/HIV
- ○ Anemia
- ○ Blood Clots
- ○ Cancer
- ○ Coronary Artery Disease
- ○ Diabetes
- ○ Gout
- ○ Heart Attack
- ○ Hemophilia
- ○ Hypertension
- ○ Kidney Disease
- ○ Liver Disease
- ○ Muscle Disease
- ○ Osteoporosis
- ○ Rheumatoid Arthritis
- ○ Osteoarthritis

Mother Medical History

- ○ AIDS/HIV
- ○ Anemia
- ○ Blood Clots
- ○ Cancer
- ○ Coronary Artery Disease
- ○ Diabetes
- ○ Gout
- ○ Heart Attack
- ○ Hemophilia
- ○ Hypertension
- ○ Kidney Disease
- ○ Liver Disease
- ○ Muscle Disease
- ○ Osteoporosis
- ○ Rheumatoid Arthritis
- ○ Osteoarthritis

Sibling Medical History

- ○ AIDS/HIV
- ○ Anemia
- ○ Blood Clots
- ○ Cancer
- ○ Coronary Artery Disease
- ○ Diabetes
- ○ Gout
- ○ Heart Attack
- ○ Hemophilia
- ○ Hypertension
- ○ Kidney Disease
- ○ Liver Disease
- ○ Muscle Disease
- ○ Osteoporosis
- ○ Rheumatoid Arthritis
- ○ Osteoarthritis

Patient Name: **Date:** **Form:** ROS

Review of Systems: If you have any of the following, Please Place Mark inside Circles

Constitutional
- O Weight Loss/Gain
- O Weakness
- O Fatigue
- O Fever

Cardiovascular
- O High Blood Pressure
- O Chest Pain
- O Rheumatic Fever
- O Palpitations
- O Has Pacemaker

Musculoskeletal
- O Joint Pain
- O Arthritis
- O Muscular Weakness
- O Stiffness
- O Muscular Pain

Eyes
- O Glasses or Contacts
- O Blurred Vision
- O Glaucoma
- O Cataracts
- O Excessive Tearing

Skin
- O Rashes
- O Sores
- O Lumps
- O Dryness
- O Itching

Blood or Lymph
- O Anemia
- O Easy Bruising
- O Easy Bleeding
- O Swollen Glands

Ear Nose Mouth Throat:
- O Ears Ringing
- O Earaches
- O Hearing Aid
- O Frequent Colds
- O Nasal Discharge
- O Hay Fever
- O Nosebleeds
- O Dentures
- O Bleeding Gums
- O Frequent Sore throats

Neurological
- O Headache
- O Dizziness
- O Seizures
- O Loss of Sensation
- O Vertigo

Gastrointestinal
- O Heart Burn
- O Rectal Bleeding
- O Abdominal Pain
- O Gallbladder trouble
- O Hepatitis

Respiratory
- O Shortness of Breath
- O Cough
- O Wheezing
- O Asthma
- O Bronchitis

Genitourinary
- O Blood in Urine
- O Urinary Infections
- O Kidney Stones
- O Burning Urination
- O Sexual Disease

Endocrine
- O Thyroid Trouble
- O Excessive Sweating
- O Excessive thirst

Immunologic
- O Reactions to Drugs
- O Skin Rashes
- O Reactions to Foods

Psychological
- O Nervousness
- O Depression
- O Mood Changes

Patient Name: **Date:** **Form:** SOC

Social History: Please respond to the following by Placing Mark inside Circles

Substance Use:

Do you:

Use Tobacco?	O Yes	O No	O Former
Use Alcohol?	O Yes	O No	
Use Caffeine?	O Yes	O No	
Use Illicit Drugs?	O Yes	O No	

I do not use any of the above O

Hand Dominance? O Right Handed O Left Handed

Females Only:

Could you be pregnant? O Yes O No

Allergies: Do you have allergies to any of the following medications or substances

O No Known Allergies	O Aspirin	
O Penicillin	O Amoxil	O Tegretol
O Codeines	O Keflex	O Bactrim
O Sulpha Drugs	O Cefzil	O Pediazole
O Iodine / Shellfish	O Ceftin	O Dilantin
O Ampicillin	O Suprax	O Novacaine
O Vantin	O Septra	O Insulin
O Depakene	O Lamictal	O Lidocaine

Other Allergies:

O Latex O IVP/X-Ray Dye O Metal O Egg/Avian (Bird)

List any other allergies in this box